Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

Respondent Name

HARTFORD FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-3054-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is a copy of the Pre-Authorization. Please note the start and end date. Our charges are well within the pre-auth period."

Amount in Dispute: $280.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier authorized 6 sessions of physical therapy. This DOS exceeds the amount authorized. Provider did not request concurrent review for an extension of services per Rule 134.600(q). Please see attached."

Response Submitted by: The Hartford, Josie Bloss, 300 South State St., Syracusse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2010	Physical Therapy Services – CPT Codes 97110, 97112, 97140	$280.00	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, requires preauthorized for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 10, 2011
   - 197, 198-Payment denied reduced for absence of, or exceeded, pre-certification/authorization. Procedure not approved by pre-authorization.

Issues

1. Did the requestor obtain preauthorization approval for the disputed physical therapy services?
   Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning."

   On October 26, 2010, the requestor obtained preauthorization approval for six (6) sessions of physical therapy, codes 97110, 97112 and 97140. The start date was October 26, 2010. The end date was December 27, 2010.

   The respondent states in the position summary that "Carrier authorized 6 sessions of physical therapy. This DOS exceeds the amount authorized. Provider did not request concurrent review for an extension of services per Rule 134.600(q). Please see attached."

   Review of the submitted documentation finds that the requestor provided physical therapy sessions on the following dates:

   97110: November 3, 2010, November 5, 2010, November 10, 2010, November 12, 2010, November 19, 2010, November 22, 2010, and November 23, 2010.

   97112: November 3, 2010, November 5, 2010, November 10, 2010, November 12, 2010, November 19, 2010, November 22, 2010, and November 23, 2010.

   97140: November 3, 2010, November 5, 2010, November 10, 2010, November 12, 2010, November 19, 2010, November 22, 2010, and November 23, 2010.

   Per 28 Texas Administrative Code §134.600(q) "The health care requiring concurrent review for an extension for previously approved services includes: (3) physical and occupational therapy services as referenced in subsection (p)(5) of this section."

   The Division finds that based upon the submitted documentation, date of service November 23, 2010 was not preauthorized per 28 Texas Administrative Code §134.600(p) or (q). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/05/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.